DENTAL INSURANCE CLAIM FORM

INFORMATION ON THE PARTICIPANT If the information contained in Section A is incorrect or incomplete, please fill in Section B.

A.

B.

Name: _____

Address: _____

_____ Postal Code: _____

Phone: _____

Group: Employer:

Identification No.:

IMPORTANT
1. For dependent child aged 18 to 26 years old, fill in section 2 on this form.
2. If dental services are necessary as the result of an accident, fill in section 3 on this form and include the x-ray(s).
3. Your claim form must be filled in within 12 months from the date dental expenses were incurred and services received.

1- INFORMATION ON THE PARTICIPANT:

_____

_____

at work _____

_____
Y M D

INFORMATION ON THE PATIENT:

Are any dental benefits or services provided under any other group insurance or dental plan, or government plan? No Yes

_____

Name of insuring agency: _____

_____
Y M D

2- STUDENT CERTIFICATE FOR CHILD AGED OVER 17 OR 20 YEARS OLD ACCORDING TO YOUR POLICY

I hereby certify that my child _____ is unmarried and attends the secondary school, college or university _____ for the fall session _____ , or winter session , as a day student on a full time basis.
First name
Name of institution
Year

3- DENTAL SERVICES REQUIRED AS THE RESULT OF AN **ACCIDENT**

No Yes If yes, indicate the date, _____
give some details, and enclose the **X-RAY(S)**. _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER AND CERTIFY THAT THE INFORMATION GIVEN IS ACCURATE

S

Signature of patient (or parent/guardian)